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ABSTRACT

This paper describes a four-phase therapeutic approach that has proven useful to adult female and male survivors of child sexual abuse. The methods described are primarily used in individual therapy, although the context is within the family therapy realm and relies heavily upon Structural Family Systems Theory. The four phases which a victim passes through before the counseling is complete are described in detail under the headings of: (1) Challenge and Education; (2) Delving Deeper and Fragile Times; (3) Rebirth and New Life Skills; and (4) Evaluation and Moving On. Specific techniques which are used at each phase are enumerated and discussed. Examples are included to illustrate the various techniques, which include guided imagery, developing a family genogram, relaxation techniques, reparenting, psychodrama, and the "Child Within" concept. (NB)

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Victim Therapy with Adult Survivors of Child Sexual Abuse

by

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Introduction

Over the years this writer was frequently overwhelmed by the number of friends, relatives, colleagues, and clients who disclosed that they had been sexually abused as children. At least it used to be a surprise. Now that child sexual abuse has attained the public prominence that the "battered child syndrome" received in the Sixties and the "battered woman" in the Seventies, the incidence rate is less shocking. Still, being good societal minimizers like the rest of the population, we have wanted to believe it is not as prevalent as it appears to be. Sadly, that is not the case, as the more recent research and clinical experience proves. The old professional guesstimate of one in six children turns out not to be far off the mark.

We can go back as far as Kinsey (1948, 1953) for findings that indicated that 25% of American women and 10% of American men had been sexually assaulted before age 18.(1) In more recent research studies the occurrence of child sexual abuse has shown a range of: 5% to 15% of the United States population (Boekelhelde, 1978) (2); 38% of San Francisco women (Russell, 1983) (3); 19% of females and 9% of males in a college student population (Finkelhor, 1979) (4); of Boston parents sampled, 15% of the women and 6% of the men (Finkelhor, 1983) (5); one in four American females with one in ten as victims of incest (Herman, 1983) (6); and so on. Additionally, reports to child protective services agencies have risen dramatically. In 1984, those agencies substantiated 100,000 reports of sexual maltreatment, a 170% increase since 1980 (American Humane Association, 1986). (7) Thus, the data and research is infinitely better than that which existed before the Eighties, but the variation in figures, partially due to differences in samples, definitions of abuse, and public awareness, demonstrates that it is still risky to cite prevalence and incidence rates as fact. Moreover, some recent work by Abel and colleagues points to a significant underreporting of sexual abuse among male children.(8)

The initial clinical work has been with the child victim, simply because abused children were at last being identified through the mandatory state reporting statutes instituted in the 1970s. However, other than through research interest (relatively recent) and therapeutic encounters (in which the right questions were rarely asked), the adult victim had little chance of being identified. Prior to the advent of the child abuse reporting laws, it was popularly estimated that 98 out of every 100 incest cases went unreported.(9) Moreover, since it occurred in the "distant" past, most people, including the victim, felt it no longer had relevance to adulthood. Of course, the family "contract of silence" contributed to the victim's desire not to open old wounds and expose the shameful secret. Credit must be given to the victim services and family violence fields, as well

as the Women's Movement, for finally bringing the problem to light. Many professionals and volunteers were learning from the battered women, rape victims, and abusers they served that they had been sexually abused as children.(10) Finally, as public consciousness was raised with books such as Kiss Daddy Goodnight (11) and television shows like "Something About Amelia"(12), grass roots groups started to spring up around the country to serve adult women survivors of child sexual abuse.(13)

This paper will describe a four-phase therapeutic approach that has proven useful to adult female and male survivors of sexual abuse.(14) Although the methods are primarily used in individual therapy, the context is very much within the family therapy realm. Quite often the abuse occurred within the home, and the therapy involves the victim's resolution of her/his(15) victim role within the family. Even, if the abuse was by a nonrelative, how the family handled the disclosure is often related to the amount of psychological damage done to the child. The therapeutic approach is largely Structural, but with great borrowings from Strategic Therapy as well.

It would have been a neater clinical picture if this particular therapy had evolved first from a Structuralist framework, since it works so well within Structural Theory. However, as with so many professionals working with sexual abuse cases, and this writer is no exception, the major clinical work was of the seat-of-the-pants variety conducted over many years in numerous direct services programs. Entry into the marriage and family field came later. However, it was soon evident that our work with victims and their families utilized many of the principles of Structural Therapy, even if the words were not always the same. This back door approach does not seem to have adversely affected the development or the effectiveness of the therapy, and it has been fun for those of us who came from different backgrounds in family violence, child welfare, and victim services to congratulate ourselves on our brilliance. We were Systems and Structural practitioners all along; we just didn't know it.

Victim Therapy Phases

In this therapy the victim passes through four phases before the counseling is complete. Naturally, the victim's progress does not always follow the phases exactly, as there is purposeful overlap, but they do provide a useful process guideline. It is important to note that marital, family counseling and group therapy appear to be ineffective unless the victim therapy is completed or well underway. In other words, the sexual victimization seems to override resolution of other therapy issues involving relationships, parenting, career, and personal

functioning: or it is at the heart of these other life issues. Depending upon the extent of emotional trauma, the victim's commitment to counseling, and the level of her growth skills, the therapy may last only six months or, more rarely, as long as two years. The Phases are:

Phase I: Challenge and Education
Phase II: Delving Deeper and Fragile Times
Phase III: Rebirth and New Life Skills
Phase IV: Evaluation and Moving On

In their work with families of sexually abused children, James and Nasjleti outline three similarly self-descriptive treatment phases: disclosure-panic, assessment-awareness, and restructure. (16)

Although somewhat less poetically descriptive, Friesen delineates the four stages of Structural-Strategic Therapy, which contain similar process milestones. They are:

1) Developing a Context and Conditions for Change
2) Confronting Patterns and Expanding Alternatives
3) Consolidating Change
4) Termination and Conducting an Evaluation of the Therapy Process (17)

Phase I: Education and Challenge

There are several critical times in victim therapy, but the client's first step is probably the most significant. The adult victim comes to us scared, anxious, confused, distrustful and unsure. She has some understanding that she is about to confront issues that she has spent most of her life avoiding, for very good reason. They are terribly painful and make her feel very bad about herself. The sheer courage and life force of our clients is something to behold. How much easier it would be to keep denying and minimizing their abusive past, to play the familiar Secrets Game, even if the price in never-found peace and happiness is high.

At this crucial point the therapist's initial calmness, empathy, and support will set the stage for relieving the client's anxiety. However, calmness does not imply a nondirective and passive approach. Following Minuchin's lead, the therapist takes a leadership position and forms a therapeutic partnership.(18) Passionate advocacy is vital. The therapist provides a balance of power on behalf of the client in opposition to her abuser(s) until she is able to do this herself in Phase II. Outrage, sadness, hurt, even tears may need to be expressed by the

therapist for or with the client. Many victims have never been given permission to express these feelings. The therapist is the role model. In Structuralist terms that is the close position in joining, forming an alliance with the client, and confirming her validity(19) as a victim and survivor. It is also a form of the unbalancing technique in that the therapist temporarily forms an alliance with the victim (child subsystem) in opposition to the abuser (often the parent subsystem). (20)

A special form of the therapist's "use of self"(21) occurs if the therapist has also been a victim and if the victim issues have been resolved in the therapist's own counseling. Sharing that one has been a victim and some of the victim feelings one has experienced can be a most powerful tool in the first and succeeding sessions. Too often victims have come across friends, loved ones, therapists, and authorities who just do not understand their anguish or why they are the way they are. To know that someone comprehends the feelings and has lived through some of the same experiences is exceptionally reassuring. It helps overcome the universal victim feeling of aloneness: I'm the only one this has happened to; I was especially bad or unlucky. The use of self also begins the process of reducing shame and guilt. It is the first step in the victim's education. A major warning sign accompanying this particular tool, however, is the fact that it will intensify transferrence. It must be used cautiously and skillfully.

The second step is to anticipate the victim's troubled areas and plant educational seeds that will bear fruit later. These seeds are the first challenge to her negative self-concept, and they also begin the process of boundary-setting by defining part of the therapist-client relationship. For example, support and empathy will not always mean agreement. By example, honesty, and unflagging commitment to the client, the therapist demonstrates that he can disagree with the victim without it being a rejection or a betrayal, and, conversely, that it is safe for the victim to disagree. The therapist's honesty and direct communication also counteract a lifetime of double messages and double binds common to abuse families. In fact, the whole victim therapy process is antithetical to the interaction set up by the abuser in which it was not safe to disagree, where there were no appropriate boundaries, and where messages were distorted (e.g. "I love you" does not also mean "I will respect and protect you").

From the start the therapist acknowledges the validity of the victim's "bad me" self concept.(22) It has been one of the childhood coping skills that helped her survive. Without taking control from her or disavowing her viewpoint, the therapist gently disagrees and firmly points out (i.e. sets a boundary) that there is also a "good me." This self is often not recognized, but she is there and one of the goals is to find her and strengthen her. Perhaps, for the first time someone is

telling the victim that she is valuable and is more than the negative person the abuser, her family, and the community may have labelled her. At this time it is important to emphasize her strengths as a survivor and any positives the therapist observes: "You really seem to love your children very much." "I can see how hard you are trying to be a good wife and mother." "You're a hard worker and I can tell you take a lot of pride in what you do." "It's amazing what you've accomplished as a single parent." "It takes a lot of courage to come in here for help." And so on. As we get to know our clients, we find we rarely have to stretch to find the positives. However, the client will not share our admiration and perceptions for quite a while.

Marilyn, age 33, held onto her "bad me" so strongly that it seemed she would never let go. She constantly disparaged her value as a parent, employee, woman, and person. She also blocked any childhood memories of her father fondling her, although she could see herself sexually touching her father. She claimed she was the real molester, even though she was only seven. Finally, after many months of resistance to the idea that her father had set up and initiated the abuse, she remembered him fondling her. She was devastated and felt totally alone. She stated she now had to face up to the fact that her father hadn't treated her special or really loved her. For years, Marilyn's "bad me" allowed her to cling to the ideal father fantasy and helped a needy seven-year-old make sense out of the abuse.

The challenge to the victim's perception of the abuse, the abuser, her family, and herself is a reframing process.(23) In the first phase the therapist rarely succeeds in getting the victim to let go of her old, homeostatic beliefs. However, through the education and reframing process, the therapist obtains her agreement that there may be other valid perspectives or that her framing of reality can be expanded or modified.

Three key Structural concepts in the victim's education are boundaries, alignment, and power.(24) They point to therapeutic goals that include:

1) Developing appropriate boundaries within the self (differentiation of self) and between the self and others (in roles as parent, spouse, friend, employee). Breaking the enmeshment and disengagement polarities with which the victim has learned to relate to others is a major objective.

2) Restructuring alignments, at least in terms of the victim's perception of her past (if her family is unavailable for assisting in her therapy in Phase II). Bowen's concept of triangles in dysfunctional families (25) is particularly helpful in conjunction with Minuchin's discussion of family subsystems and roles.(26) Besides the Abuser, the family roles the victim will often have seen include: the

Scapegoat, the Referee, the Princess, the Favorite, the Caretaker, the Helpless Mother, and so on.

3) Empowering the survivor. This is probably the most crucial goal. Little can be accomplished until the victim feels she has power and is in control (without being controlling).

Some borrowings from Strategic Therapy are necessary to round out her education, particularly the emphasis on the change process and family communication. (27)

These goals, methods, and perspectives are translated in ways that the client can understand. Total comprehension is not necessary. This is just the introduction to a new view of her victimization. The challenge to her perceptions is done carefully, so it does not become overpowering. At the same time the therapist is a little like the surgeon, who, in an emergency, must cut quickly and deeply with a sharp scalpel to reach the damage. The therapist is cutting through years of denial and minimization and demonstrating to the client that, with help, she can survive the surgery and healing process.

The specific techniques used in Phase I are discussed below:

1) "The Story of the Nine-Year-Old Girl" is a true story (28) that young and old victims find empowering and hopeful. It can be used very early in Phase I. The sex of the child may be changed for male victims. The story begins:

"Once upon a time there was a nine-year-old girl who lived with her Mommy and Daddy. One night she was asleep, when she suddenly woke up and saw her Daddy standing next to her bed. Her Daddy put his finger to his lips and said, 'Shhh.' He started rubbing her arms and back, which felt good, although she thought it was a little strange that late at night. Then, he put his hand on her legs and she got nervous, because he moved his hand up between her legs. She said, 'Stop Daddy' several times, but he wouldn't listen. She got angry when he wouldn't stop, cocked her fist and went 'Wop' right on his nose. She broke his nose, and he stumbled out of the room. Her Mommy woke up and he said he had run into the door in the dark.

The little girl didn't know what to do. She loved her Daddy and was very confused by what he did. She decided to hope he loved her and would never do it again. Unfortunately, Daddy was like a lot of sex offenders. He didn't learn quickly and he wasn't very respectful of his daughter's feelings. So, a few weeks later she woke up to find him in her room again. He told her to be quiet, that he wouldn't hurt her, and he put his hand between her legs again. But she was a very smart little girl and had kept a baseball bat in her bed since the last time. So she hit Daddy in the arm with the bat and broke his arm. He stumbled into the

hall again and the Mommy woke up. He tried to say he fell and hurt his arm, but the little girl spoke up and said, 'No, Mommy, that's not what happened. I hit Daddy because he tried to put his hand between my legs again, even when I told him to stop.' The mother immediately told him to leave and not come back until he got counseling help and could be a good father and husband."

Even though this sounds like a child's story, it seems to hit the same responsive chord in adults, almost as if their "child within" was the listener. The story may bother some because of the violence in it, but even children seem to understand it is a power metaphor, not a recommended action. Also, the elements of a mother who really did protect, a Daddy the child fervently wanted to love and to treat her well, and the child's initial confusion touch emotional buttons for nearly all incest victims, even if their story did not have such an empowering ending. The victim feels good to hear that someone successfully stopped it; maybe I can be strong too. During a family therapy session with a ten-year-old victim, her 15-year-old brother (the abuser), and their mother, this writer encouraged the victim to talk about her brother and how he had hurt her. Near the end the child was asked if there was anything else she wanted to add. With a shy smile she asked the author to tell her brother "The Story of the Nine-Year-Old Girl." The child was very clearly using the therapist as her baseball bat.

2) The concept of the "Child Within" is introduced early in this phase. Interestingly, therapists across the country have independently explored this phenomenon, often using the same descriptive words.(29) In this writer's experience every adult victim has an identifiable "feeling area" or ego state (sometimes more than one) that corresponds to an age in which the impact of the victimization hit hardest. Ages five to eight are particularly common. The "feeling area" almost appears to be a distinct personality, but the client usually would not be classified as a true Multiple Personality Disorder, except in the rare cases when that diagnosis is appropriate.

Many victims have a great deal of difficulty remembering their childhood. They do not want to remember; the Child Within is in such pain. They have tried to dissociate themselves from their victim self, another version of the perceived "bad me." From life history facts and pictures in Jean's family album, it is clear that at age ten she was very sad and lost. In that year she was molested by a stranger and a babysitter; it was the third year of her uncle's continued sexual abuse; her grandmother died and she thought she was to blame; her physically and emotionally abusive mother remarried; and her new stepfather sold her dog, a favorite pet. Identifying this traumatized ten-year-old has been indispensable to Jean's therapy and eventual healing. Others have less dramatic trauma ages, but the child's characteristics are generally similar: sad, confused, lost, angry, hurt,

betrayed, shell-shocked, self-hating, guilty.

3) Recent research has shown that as many as one-third of sexual abuse victims suffer from Post Traumatic Stress Disorder (PTSD).(30) Reviewing the specific DSM-III clinical symptoms and characteristics of the syndrome often alleviates the victims' fear that they are crazy. Recognizing that the disorder is trauma-based, and not personality-based or a psychotic disorder, helps them feel less alone and hopeless.

Ellen is a perfect example. For years she had heard a voice in her head that said, "I'm going to kill you." Not so long ago many would have agreed that she was clearly having auditory hallucinations, indicating psychotic episodes.(31) In therapy, Ellen finally remembered that at age five her father had nearly strangled her after molesting her. He threatened to kill her if she ever told anyone. Thirty-five years later she recognized the voice and the causal trauma.

4) In cases where the information is available, developing a three or four generation family genogram(32) can be very useful to both the client and the therapist in analyzing family patterns; observing the intergenerational transmission of sexual abuse, as well as other dysfunctional messages; identifying relatives who may be supports for the victim, especially those who appear to have suffered similar treatment; and helping the victim take the focus off herself as the unlucky or bad child. The genogram illustrates the dynamics of the victimization as a family pattern, thus relieving the victim of individual responsibility for the abuse.

Phase II: Delving Deeper and Fragile Times

Many of the techniques and much of the information from Phase I are repeated throughout the rest of the therapy until cognitive restructuring and behavioral changes confirm that the messages have been received and understood. Phase II is probably the most difficult phase for the client, because she will be dealing with her most painful experiences, past and present. She will feel very exposed and vulnerable. Victims have said it is a time when they feel better than ever before, because they know it is all finally coming out, and, simultaneously, they have never felt worse. However, when feeling so fragile, there is little comfort in knowing that one is getting healthier.

At the beginning of Phase II, the therapist explores the victimization in more detail at a pace the client can accept without feeling too overwhelmed. The therapist must create an atmosphere that is relatively safe, while acknowledging that at

times it will be a painful process. It is stressed that the hurt will be short-lived, in almost all cases lasting no more than a few weeks to a few months, and that there is a considerable amount of relief in breaking the Secrets Game. Almost without exception the release of the pent-up emotions frees the victim from her standard "numbing out" process, thus initiating change.

Techniques used in Phase II are sequentially outlined below:

1) Since many victims suppress childhood memories or feel very distant from the child they were, the "Family Album Technique" commences filling in the gaps. The victim brings in all the pictures she has of her family and herself. In chronological order the therapist reviews the pictures with the client, continuing the reframing process as the client fills in family history and interprets how she sees the pictures. Although the client generally does not see it at first, in many cases the abused child stares out at us over the years.

Rachel, age 24, is typical. In her early years, she appeared to be a happy, spontaneous, nurtured child, despite her parents' divorce when she was five. Her mother remarried and her stepfather abused her from ages six to 13. The change in expression and body language throughout the rest of the family album was striking. After age six the sad, haunted, lost, withdrawn victim peeked out of every picture, even into her late teens. Through the pictures Rachel also saw the impact of the abuse on her brother, another victim, and her unhappily married mother.

The Family Album guides the victim back to her childhood and to her feelings about each family member. Rachel finally began expressing her anger at her stepfather and mother, as well as guilt about not being able to protect her little brother. The therapist discerns family roles and dynamics more clearly as the pictures and family history are discussed.

2) The use of relaxation techniques and Guided Imagery often improves recall of unwanted memories. A good starting place is the victim's Child Within. After a relaxation exercise, the therapist asks the client to describe herself around the age of the identified Child Within. This includes what she was wearing, what she looked like, the expression on her face, and so on. It is important to emphasize to the client that she should not worry if she feels like she is making things up. She is also directed not to think about her responses, but state the first thing that comes to mind.

The therapist will often have to aid the client in emotionally connecting with her little girl, since she will not want to remember her. The therapist can begin suggesting how the child might look and feel (sad, hopeless, lost, confused, lonely,

etc.). It usually does not take long to hit the right buttons, as evidenced by the client's expression, and often her tears.

When that has been accomplished, the therapist requests the client to pick a place where she thinks she was abused; the bedroom, the kitchen, a field. Then, she is asked to put her abuser in the picture. The same process of description is followed: what is he wearing? what is the expression on his face? how is he looking at her? and so on. At this time the client is asked to describe an abusive incident. She may need promptings if she blocks the memory. An important prompt is to say, "Visualize his hands: What are they doing?" This generally strikes a chord, since most abused children remember his hands, often larger than life. If the client is handling the review well, later prompts are to ask if she can see his penis and where it is, or if she can see what her hands are doing.

The Guided Imagery is usually conducted over several sessions, since it is generally upsetting to the client. In one session a victim went no farther than the memory of his hands moving up her legs. She became too agitated to continue and was relieved that she did not have to go on. As with all victims, allowing them to maintain control is always a primary therapeutic concern. She was able to continue at a later date.

In this writer's experience the memories from the Guided Imagery are genuine, even if the victim feels she cannot clearly "see" the memory. Eventually, they become more complete. Nearly always, this review pushes other memories to the surface. For a short while this surfacing may become uncontrollable, occurring at home, at work, in nightmares, and in therapy. The victim needs to be reassured that this is a normal part of the process, it is healthy, and it will last only a short time. The therapist must be available during this time for extra sessions, as the victim often experiences feelings of panic and depression, sometimes with suicidal ideation. Some will actually regress to feeling that they are the Child Within, and act as that abused child must have felt and acted. It is a very unnerving period, especially since many will remember sexual activities that they believed they had been able to avoid, such as oral sex or intercourse. Like the abused child they will feel powerless.

Some victims so strongly resist the memories that hypnotherapy may be the technique of choice.

3) "Phantom Memories" are a frequent albeit unrecognized symptom of sexual abuse. Gina, age 28, recalled that during stressful times she experienced a tightness in her throat and chest. This appeared to be nothing more than a common anxiety symptom. However, one time when she was performing fellatio on her husband, he grabbed her head in his excitement. She immediately became violently angry at him. Putting that incident

together with a discussion of Phantom Memories, she finally recollected during a Guided Imagery session that her father had forced her to perform oral sex. Her throat had felt tight, as if she were choking, and she remembered the weight of his hand on her chest.

A 55-year-old woman stated that she had had a sensation of slime in her throat for some fifty years. She finally recalled that her father had ejaculated down her throat and it felt slimy. Other sensations victims have reported include: nausea (apparently related to oral sex), numbness around the breasts and genitals, a ball of fire in the stomach, tight throat and jaw muscles, a sense of being smothered, and so on. To paraphrase psychoanalytic thought, it seems to be a case of "the body remembers what the mind forgets."

4) "Back to the Future" was an enjoyable movie, both as entertainment and as an interesting psychological premise. The young man in the movie was accidentally transported back to his parents' youth, and was not only instrumental in setting up their first date, but his intervention significantly changed them for the better. How many of us have not wished at one time or another for such power.

The movie spawned an interesting idea. What if the victim could go back to her Child Within? How could she help that abused little girl? Either in session or as a homework exercise, the victim is asked to imagine that she can go back for one hour to the child she was. She cannot change anything that will happen to the child. What will she do? What does that child need from her? How can she best meet that child's needs?

Joann, age 23, chose to return to her 13-year-old, who had just been brutally raped by her stepfather. She imagined this frightened little girl in her nightgown shaking and sobbing on her bed, just as it had really happened. Joann started crying and said she would just hug her at first; hold onto her as if she were clinging to life. She started talking to the child, "You'll be okay. It's not your fault. You didn't do anything wrong and there was no way you could have stopped it. He's sick and you're not. He's going to do it again, but I want you to know you will survive and come out okay someday. I love you!"

Joann sobbed throughout the exercise and it was obvious she was talking to herself; giving support as she had never been able to before. This one session relieved a tremendous amount of guilt and helpless feelings. She became her own mother, only this one protected her.

The Back to the Future Exercise aids the victim in joining her victim child emotionally. Up to this point Joann had typically resisted getting to know this child or getting in touch with the

child's feelings. In fact, she said she felt the child was a monster. As she joined the child, she was able to see her in a new light -- no longer as just bad, needy and trapped, but also as strong, protective of her little sister, hopeful, caring, and normal.

This exercise is essentially a reparenting technique. The adult survivor is able to share her new knowledge and adult perspective with the young Child Within, and help her make sense out of the chaos. It is a recognition that her own parents cannot or will not abet and protect her, so she must become her own advocate.

As a follow-up to the Back to the Future Technique, the victim is instructed to pretend that her Child Within is always with her holding her hand. It is the adult's task to be her mother and friend, to talk with her about how life is turning out and educate her, just as she was educated in Phase I. Joann laughingly envisaged her three Children Within (ages 4, 8, and 13) following her around. She had many warm images of spontaneously enfolding them in her embrace. The integration of the Child Within and the resolution of the victim experience was well underway if Joann was able to laugh and feel warmly about her former "Monster Child."

5) To further encourage the client's emancipation from repressed feelings, cognitive-behavioral homework assignments(33) are particularly useful. These include: anger letters (e.g. to the abuser or to a nonprotective mother), grief letters (e.g. to the Child Within, an abused sibling, or a dead parent), and Feeling Diaries. These tasks are safe, since the victim can choose what to do with them.

Psychodrama can also be a beneficial instrument. Maria's aunt had been her only advocate in the face of a physically abusive mother and a sexually abusive uncle. When she died, Maria was not allowed to attend the funeral. Seven years later Maria was still overcome with grief and unable to work on her other victimization issues. In the office she created a funeral ceremony the way she would have wanted it to be and told her aunt how she felt about her. It was a very moving experience and the grief was finally resolved. This resolution provided the model for working through other abandonment and separation emotions.

6) When family members are available, the completion of Phase II is enhanced by their participation in the therapy. The objective is not to conduct family therapy, although that may later grow out of the sessions, but to help the victim obtain more accurate information about her past, to learn how her family perceived her, to identify family roles and dynamics (e.g. family triangles), and to break the "contract of silence." It also provides the victim with an opportunity to express her feelings in a secure setting, thus disrupting the old family power patterns.

It is not uncommon in an incest situation for a mother and daughter to resolve their estrangement, when the mother is willing to hear what happened to her daughter and share her pain. Mothers who have done this were finally able to form an alliance with the victim, while acknowledging their past co-dependency with the abuser. Daughters have come away with a better understanding that their mothers were often secondary victims (or past victims themselves), and that their inability to protect did not indicate a lack of love or desire to protect.

Sharing among siblings who have been abused is very healing and often reverses the sibling warfare common to these families. Equally beneficial, but more difficult to arrange, are sessions between the victim and her abuser. Some victims do not wish to ever face their abuser, but for those that do, the therapeutic setting places the victim in the power role. This writer also works with sex offenders, and there have been instances of a victim visiting the father's therapy group (with his permission) and confronting him. The other offenders have always been supportive of the victim's feelings, and have challenged the abuser's cognitive distortions and attempts to minimize his behavior. Invariably, the victim has come away empowered and validated.

Phase III: Rebirth and New Life Skills

There is an end to the fragile times. The weeping, the roller coaster moods, the bursts of rage, the feeling out of control, and the fear are replaced by new-found confidence. I can survive. I can make it. There is often an inner calm and sense of wholeness that the victim has never experienced before. To witness the change reminds one of a birth. This is the person that was struggling to emerge for years. This is the child full of promise before the abuse. It is a new beginning. Another analogy that many victims find meaningful is the butterfly leaving her cocoon and spreading her wings for the first time.

This rebirth will not take firm hold for some time, but it is usually here to stay. By this time the client will have learned or is ready to learn new life skills. Although these skills have not been enumerated in this paper, many of these are part of the victim therapist's standard training repertoire. They include: communication skills, assertiveness training, social skills, parenting techniques, anger control, and so on. At this phase it is also appropriate for the client to enter adjunctive therapies, such as victim group therapy, marital counseling, family therapy, or individual therapy for non-victim problems and personal growth. Chemical dependency treatment is the only supplemental

therapy that would be necessary in Phase I. Support groups such as Alcoholics Anonymous, Narcotics Anonymous, Alanon, ACA (Adult Children of Alcoholics), Overeaters Anonymous, and so on will greatly assist the recovery process in any of the four phases.

Much of this phase is spent on getting acquainted with the new range of feelings being encountered and practicing the new life skills. Many victims find it quite frightening as they convert from their familiar negative feeling state to a positive sense of self. Even the first feelings of happiness are dismaying, as if the victim does not know how to trust such a strange feeling. Will it last or is something bad about to happen as it always did before? Some have described the rebirth as landing on an alien landscape. This generally lasts only a few weeks, since the victim begins to see how well her new life skills work compared to the old way. Still, this is another critical time for therapist support, since the victim may perceive the usual bumps and falls of life as more evidence of failure.

Phase IV: Evaluation and Moving On

Both victim and therapist usually sense when termination is approaching. Since separation and affiliation are primary issues for victims, this can be quite disturbing. Some regression or anxiety may occur as the victim attempts to hang on.

As part of the therapist's role modeling of direct communication, he will need to raise the matter if the victim cannot. Examination of her progress, discussion of her fears and the role therapy has played in her growth, and reducing the number of sessions to biweekly, then monthly, are all necessary elements of the termination process. Lastly, any lingering transferrence reactions need to be resolved. Perhaps, the most significant concept to convey is that she will always have an open door to therapy. Refresher courses are the norm.

The therapist-client celebration for moving on can range from something as simple as a hug, or sharing tears of joy, to joining a celebration meal with a healed survivor and her unified family.

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(11) L. Armstrong, Kiss Daddy Goodnight (New York: Pocket Books, 1978).

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(13) For example, in 1983, K. Langford and C. Yeardley founded Project Resolve in Miami, Florida. It is a volunteer-based,

grassroots program providing group therapy for children, adolescent, and adult sexual abuse victims.

(14) Many of the techniques described in this paper can be used with children and adolescents, and are also applicable to treatment of battered women, rape victims, and victims of physical and/or emotional abuse.

(15) This writer works with both female and male victims. For purposes of writing ease, clients will be referred to as females throughout the rest of the paper. Likewise, since this writer is male, male pronouns will sometimes be used to refer to the therapist. Obviously, female therapists conduct this work as well, and far outnumber their male counterparts.

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(17) J.D. Friesen, Structural-Strategic Marriage and Family Therapy (New York: Gardner Press, 1985), p.11.

(18) S. Minuchin and H.C. Fishman, Family Therapy Techniques (Cambridge: Harvard University Press, 1981), pp.28-29.

(19) Ibid, p.33.

(20) Ibid, pp.161-162.

(21) Ibid, pp.30-33.

(22) Dr. Doris Stiles and Dr. Raymond Armstrong (Coral Gables, Florida) have emphasized this point based upon their years of work with victims. They point out that many therapists needlessly become enmeshed with the victim by fighting her negative self-concept, in effect recreating the abuser's stance that her beliefs have no validity.

(23) Minuchin and Fishman, Family Therapy Techniques, pp.73-77.

(24) Friesen, Structural-Strategic Therapy, p.14.

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(26) Minuchin and Fishman, Family Therapy Techniques, pp.11-27.

(27) Friesen, Structural-Strategic Therapy, pp.14-15.

(28) This writer first heard the story from Dr. William Samek (Miami, Florida), who has used the story in his work with offenders and victims.

(29) Dr. Roland Summit also uses the concept of the "Child Within" in his work with victims at the Harbor-UCLA Medical Center. He discussed this approach in a panel presentation at the Fourth National Conference on the Sexual Victimization of Children, New Orleans, Louisiana, May 17, 1986.

(30) C.A. Monroe-Posey, "Post-traumatic Stress in Father-Daughter Incest Victims," paper presented at the Fourth National Conference on the Sexual Victimization of Children, New Orleans, Louisiana, May 16, 1986; also an excellent discussion on PTSD is found in an article by Denise Gelinas, "The Persisting Negative Effects of Incest," Psychiatry 46 (November 1983): 315-319.

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